

§ 421.1

421.505 Termination and extension of non-random prepayment complex medical review.

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

SOURCE: 45 FR 42179, June 23, 1980, unless otherwise noted.

Subpart A—Scope, Definitions, and General Provisions

§ 421.1 Basis, applicability, and scope.

(a) *Basis.* This part is based on the provisions of the following sections of the Act:

Section 1124—Requirements for disclosure of certain information.

Sections 1816 and 1842—Provisions relating to the administration of Parts A and B.

Section 1893—Requirements for protecting the integrity of the Medicare program.

(b) *Applicability.* The provisions of this part apply to agreements with Part A (Hospital Insurance) fiscal intermediaries that received awards under sections 1816 or 1842 of the Act prior to October 1, 2005, contracts with Part B (Supplementary Medical Insurance) carriers that received awards under sections 1816 or 1842 of the Act prior to October 1, 2005, and contracts with Medicare integrity program contractors that perform program integrity functions.

(c) *Scope.* The scope of this part—

(1) Specifies that CMS may perform certain functions directly or by contract.

(2) Specifies criteria and standards CMS uses in evaluating the performance of fiscal intermediaries' successor entities and in assigning or reassigning a provider or providers to particular fiscal intermediaries.

(3) Provides the opportunity for a hearing for fiscal intermediaries and carriers affected by certain adverse actions.

(4) Provides adversely affected fiscal intermediaries an opportunity for judicial review of certain hearing decisions.

(5) Sets forth requirements related to contracts with Medicare integrity program contractors.

[72 FR 48886, Aug. 24, 2007]

42 CFR Ch. IV (10–1–11 Edition)

§ 421.3 Definitions.

As used in this part—

Intermediary means an entity that has a contract with CMS (under statutory provisions in effect prior to October 1, 2005) to determine and make Medicare payments for Part A or Part B benefits payable on a cost basis (or under the prospective payment system for hospitals) and to perform other related functions. For purposes of applying the performance criteria in § 421.120 and the performance standards in § 421.122 and any adverse action resulting from that application, the term “intermediary” also means a Blue Cross plan that has entered into a sub-contract approved by CMS with the Blue Cross and Blue Shield Association to perform intermediary functions.

[71 FR 68228, Nov. 24, 2006]

§ 421.5 General provisions.

(a) *Competitive bidding not required for carriers.* CMS may enter into contracts with carriers, or with intermediaries to act as carriers in certain circumstances, without regard to section 3709 of the U.S. Revised Statutes or any other provision of law that requires competitive bidding.

(b) *Indemnification of intermediaries and carriers.* Intermediaries and carriers act on behalf of CMS in carrying out certain administrative responsibilities that the law imposes. Accordingly, their agreements and contracts contain clauses providing for indemnification with respect to actions taken on behalf of CMS and CMS is the real party of interest in any litigation involving the administration of the program.

(c) *Use of intermediaries to perform carrier functions.* CMS may contract with an intermediary to perform carrier functions with respect to services for which Part B payment is made to a provider.

(d) *Nonrenewal of agreement or contract.* Notwithstanding any of the provisions of this part, CMS has the authority not to renew an agreement or contract when its term expires.

(e) *Intermediary availability in an area.* For more effective and efficient administration of the program, CMS retains the right to expand or diminish the

geographical area in which an intermediary is available to serve providers.

(f) *Provision for automatic renewal.* Agreements and contracts under this part may contain automatic renewal clauses for continuation from term to term unless either party gives notice, within timeframes specified in the agreement or contract, of its intention not to renew.

[45 FR 42179, June 23, 1980, as amended at 54 FR 4026, Jan. 27, 1989]

Subpart B—Intermediaries

§ 421.100 Intermediary functions.

An agreement between CMS and an intermediary specifies the functions to be performed by the intermediary.

(a) *Mandatory functions.* The contract must include the following functions:

(1) Determining the amount of payments to be made to providers for covered services furnished to Medicare beneficiaries.

(2) Making the payments.

(b) *Additional functions.* The contract may include any or all of the following functions:

(1) Any or all of the program integrity functions described in § 421.304, provided the intermediary is continuing those functions under an agreement entered into under section 1816 of the Act that was in effect on August 21, 1996, and they do not duplicate work being performed under a Medicare integrity program contract.

(2) Undertaking to adjust incorrect payments and recover overpayments when it is determined that an overpayment was made.

(3) Furnishing to CMS timely information and reports that CMS requests in order to carry out its responsibilities in the administration of the Medicare program.

(4) Establishing and maintaining procedures as approved by CMS for the redetermination of payment determinations.

(5) Maintaining records and making available to CMS the records necessary for verification of payments and for other related purposes.

(6) Upon inquiry, assisting individuals for matters pertaining to an intermediary agreement.

(7) Serving as a channel of communication to and from CMS of information, instructions, and other material as necessary for the effective and efficient performance of an intermediary agreement.

(8) Undertaking other functions as mutually agreed to by CMS and the intermediary.

(c) *Dual intermediary responsibilities.* Regarding the responsibility for service to provider-based HHAs and provider-based hospices, where the HHA or the hospice and its parent provider will be served by different intermediaries, the designated regional intermediary will process bills, make coverage determinations, and make payments to the HHAs and the hospices. The intermediary or Medicare integrity program contractor serving the parent provider will perform all fiscal functions, including audits and settlement of the Medicare cost reports and the HHA and hospice supplement worksheets.

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§ 421.103 Payment to providers.

Providers are assigned to intermediaries in accordance with § 421.104. As the Medicare Administrative Contractors (MACs) are implemented, providers are reassigned from intermediaries to MACs in accordance with § 412.404 of this chapter.

[71 FR 68228, Nov. 24, 2006]

§ 421.104 Assignment of providers of services to intermediaries during transition to Medicare Administrative Contractors (MACs).

(a) Beginning October 1, 2005, CMS assigns providers of services and other entities that may bill Part A benefits to intermediaries in a manner that will best support the transition to Medicare Administrative Contractors (MACs) under section 1874A of the Act in accordance with subpart E of this part.

(b) These providers of services and other entities must continue to bill the intermediary that they were billing prior to October 1, 2005, until one of the following events occurs:

(1) The intermediary's agreement with CMS ends, and the provider or entity is directed by CMS to bill another CMS contractor.